Filed for intro on 02/05/2001
SENATE BILL 829 By
Burchett

HOUSE BILL 724
By Buttry

AN ACT to amend Tennessee Code Annotated, Title 4; Title 33; Title 48; Title 56 and Title 71, to enact the "Comprehensive TennCare Reform and Health Insurance Program of 2001."

WHEREAS, the program currently known as TennCare has provided an opportunity for more than five hundred thousand (500,000) persons who were previously uninsured or uninsurable to participate in a managed care health program; and

WHEREAS, the TennCare program provided the nation with an opportunity to experiment in applying managed care approaches to providing health care to its citizens; and

WHEREAS, subsequent federal programs, such as the "State Children's Health Insurance Program" of the "Balanced Budget Act of 1997," Pub. Law 105-33, have provided Tennessee with additional resources and approaches to health care; and

WHEREAS, modifications to the TennCare program are desirable to bridge between federal entitlement programs, such as Medicaid and TennCare, and private insurance programs; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The purpose of this act is to make possible managed care medical assistance to those recipients determined to be eligible under Title 71, Chapter 5, Part 1, to

receive medical assistance that conforms to the requirements of title XIX of the Social Security Act including any federal waiver and the regulations promulgated pursuant thereto including modifications made by the "Balanced Budget Act of 1997", Pub. Law No. 105-33, and to create a comprehensive health insurance pool to provide access to Tennessee residents who are denied health insurance because they are considered uninsurable. It is further the intent of this act to provide a mechanism that assists such persons who are unable to directly obtain health insurance coverage on an individual or group basis under any plan to obtain comprehensive health insurance.

PART 1 -- COMPREHENSIVE HEALTH POOL PROGRAM

SECTION 2. This act shall be known as and may be cited as the "Comprehensive Health Insurance Program of 2001."

SECTION 3. Tennessee Code Annotated, Title 56, is amended by adding Sections 2 through 23 as a new chapter.

SECTION 4. As used in this chapter, unless the context otherwise requires:

(1) "Board" means the board of directors of the pool;

(2) "Commissioner" means the commissioner of finance and administration;

(3) "Health care institution" means any facility, institution, agency or place as defined in § 68-11-102;

(4) "Health care provider" means any physician, institution or a health care professional, who is licensed in Tennessee and entitled to reimbursement for health care services under this title;

(5) "Health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

(6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contracts. "Health insurance" does not include short term, accident, fixed indemnity, long-term care insurance, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(7) "Health maintenance organization" or "HMO" means an organization as defined in § 56-32-202;

(8) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contracts; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not subject to Tennessee premium taxes; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by Medicare or other governmental benefits. "Health plan" includes coverage through "health insurance," as defined under this section, and specifically excludes those types of programs excluded under the definition of "health insurance" in this section;

(9) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or other health care plan;

(10) "Insurer" means any insurance company authorized to transact accident and sickness insurance business in this state, any hospital and medical service corporation, and any health maintenance organization;

(11) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., as amended;

(12) "Plan of operation" means the pool, including articles, bylaws and operating rules, adopted by the board pursuant to § 6 of this act;

(13) "Pool" means the Tennessee comprehensive health insurance pool as created in § 5 of this act;

(14) "Preferred provider organization" means any person, partnership, association, corporation or entity which contracts with a hospital, hospitals and/or other health care providers for the provision of health care services by the hospital, hospitals and/or health care providers at a discounted rate, a per diem charge or any other pricing arrangement which is less than the charge made for medical services without such a contract arrangement;

(15) "Resident of this state" means continuous physical presence and maintenance of a dwelling place within this state; provided, that absence from the state for short periods of time shall not affect the establishment of a residence; and

(16) "Uninsurable" means a person who is unable to purchase health insurance due to an existing medical condition, who is not otherwise eligible for medical assistance under this act or Tennessee Code Annotated, Title 71, Chapter 5, and who otherwise meets the eligibility requirements under this chapter. The commissioner with the assistance of the commissioner of commerce and insurance, shall develop rules to make ineligible those individuals who for the purpose of becoming eligible under this chapter

do not enroll in employer-sponsored health insurance plans in a timely fashion and thereby become uninsured with respect to such plan. To the extent the commissioner determines it is cost effective, uninsurable may also include a person who has some insurance coverage but whose coverage excludes or waives preexisting conditions if such person otherwise meets the eligibility requirements for pool.

SECTION 5. The following criteria shall govern the operation of the pool:

(1) There is hereby created a nonprofit entity to be known as the Tennessee comprehensive health insurance pool. All insurers issuing health insurance in this state and providing health plan benefits in this state on and after July 1, 2002, shall be members of the pool. Any person, partnership, association, corporation or entity operating a health maintenance organization in the state on or after July 1, 2002, shall also be members of the pool;

(2) The commissioner shall, within ninety (90) days after July 1, 2001, give notice to all insurers of the time and place for the initial organizational meetings of the pool. The commissioner shall select the eleven (11) member board of directors. The board shall at all times, to the extent possible, include at least one (1) representative of a domestic insurance company licensed to transact health insurance, one (1) representative of a foreign insurance company, one (1) representative of a domestic nonprofit health care service plan, one (1) representative of a health maintenance organization, one (1) doctor of medicine, one (1) hospital administrator, one (1) person covered by the Tennessee comprehensive health insurance pool, one (1) member from the general public who is not associated with the medical profession, a hospital or an insurer, and one (1) member to represent a group considered to be "uninsurable." In making appointments to the comprehensive health insurance pool board of directors, the commissioner shall strive to ensure that at least one (1) person serving on the board is sixty (60) years of age or

older and that at least one (1) person serving on the board is a member of a racial minority;

(3) The original board of directors shall be appointed for the following terms: three (3) members for a term of one (1) year, three (3) members for a term of two (2) years, and three (3) members for a term of three (3) years. Thereafter, all board members shall be appointed by the commissioner for a term of three (3) years. Board members shall receive no compensation but shall be reimbursed for all travel expenses in accordance with the travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter;

(4) The board, on an annual basis, shall submit to the commissioner and the comptroller of the treasury a funding plan and a plan for operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool and its financial solvency based upon timely and accurate actuarial assumptions. The commissioner and the comptroller of the treasury shall approve the funding plan and the plan of operation if they determine that the plans assure the financial solvency of the pool, the fair, reasonable and equitable administration of the pool, provide for the sharing of pool losses on an equitable, proportionate basis among the members of the pool, and otherwise is in compliance with the provisions of this chapter; and

(5) Board members are state officials and as such are absolutely immune from liability for acts or omissions within the scope of their duties as board members, except for willful, malicious or criminal acts, or omissions done for personal gain.

SECTION 6. The plan of operation submitted by the board to the commissioner shall:

(1) Establish procedures for the handling and accounting of the assets and moneys of the pool;

(2) Establish regular times and places for a meeting of the board of directors;

(3) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner;

(4) Contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

(5) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Establish the amount of assessment pursuant to § 7 of this act, which shall occur annually at the end of each calendar year, and which shall be due and payable within thirty (30) days of the receipt of the assessment notice;

(7) Select an administrator in accordance with § 12 of this act; and

(8) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

SECTION 7. The board has the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under § 4 of this act. In addition thereto, the board has the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or to be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool. For the purposes of this provision, as well as for legal representation of the Tennessee comprehensive health insurance pool, the Tennessee comprehensive health

insurance pool is considered to be an instrumentality of the state for the purposes of being represented by the attorney general and reporter, pursuant to § 8-6-109.

(3) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

(4) Assess members of the pool in accordance with the provisions of this chapter, and to make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any such interim expenses will be credited as offsets against any regular assessments due following the close of the calendar year;

(5) Issue policies of insurance in accordance with the requirements of this chapter;

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(7) Request an annual audit by the comptroller of the treasury as otherwise provided by law or, with the prior written approval of the comptroller of the treasury, contract with an independent public accountant for the audit; and

(8) Determine the eligibility requirements for plan participants and their dependents in accordance with the provisions of this act.

SECTION 8. The board of directors shall submit, not later than October 1 of each year, a financial report for the preceding fiscal year in a form approved by the commissioner. The

board of directors shall further report to the appropriate standing committees of each house by April 1 of each year.

SECTION 9. The pool shall not provide coverage to any individual who, on the effective date of the coverage applied for, already has or would have coverage substantially equivalent to pool coverage as an insured or covered dependent or who would be eligible for such coverage if such individual elected to obtain it.

SECTION 10.

(a)

(1) The pool shall be funded in the manner set forth in this section.

(2) The pool shall collect premiums from plan participants in accordance with Sections 14 through 18 of this act.

(b) Following the close of each fiscal year, the commissioner shall prepare a report analyzing the pool's projected revenues and expenditures and funding requirements. The commissioner shall present this report, together with the board's comments, to the general assembly and the governor with a recommendation for the funding of the pool.

(c)

(1) Should the pool's claims payments and other expenses exceed the premiums collected and the state appropriation, the pool members shall be assessed by the board for the amount of the shortfall.

(2) The total amount of the assessments authorized under this subsection shall at no time exceed the amount appropriated by the state to the pool.

(3) Each pool member's proportion of the shortfall shall be equal to that member's proportion of its premium and subscriber contract charges for health

insurance written in the state during the preceding calendar year as compared to the total of all premiums and subscriber contract charges written in the state. Each member's proportion of the shortfall shall be determined by the board based upon annual statements filed with the department of commerce and insurance, or such other reports or information deemed necessary by the board.

(d) The commissioner of commerce and insurance, with the approval of the commissioner of finance and administration, may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the commissioners of commerce and insurance and finance and administration, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (c). The member receiving such abatement or deferment shall remain liable to the pool for deficiency for four (4) years.

(e) It is unlawful for any member to fail or refuse to pay an assessment or to respond to an inquiry from the pool or the commissioner regarding information necessary to make assessments within forty-five (45) days of the assessment notice or request for information.

(f) Whenever the commissioner has reason to believe that a member has failed or refused to pay an assessment, or has failed or refused to respond to a request for information necessary to make assessments in a timely fashion or has failed or refused to register in accordance with the provisions of this act, the commissioner may issue and serve upon such a member a notice of hearing to determine whether the member has failed or refused to pay an assessment or respond to an inquiry or register in a

timely fashion. Such hearing shall be conducted in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(g) If, after notice and hearing, the commissioner determines that the member has failed or refused to pay an assessment, or has failed or refused to provide information necessary to make assessments in accordance with this act, or has failed or refused to register in accordance with the provisions of this act, the commissioner may assess a civil penalty of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000) for each and every act or violation. Each day in which the member has failed or refused to pay an assessment or to provide information necessary to make assessments or register in accordance with this act constitutes a separate act or violation. The commissioner may, if the commissioner determines that the member knew or reasonably should have known that such member was in violation of this act, suspend or revoke the member's certificate of authority to transact insurance business in this state.

SECTION 11.

(a) Any individual person, including the individual's eligible dependents as defined by the board, who is a resident of this state and meets the definition of uninsurable under Section 4 of this act, shall be eligible for coverage, except the following:

(1) Persons who have or who are eligible to have on the day of issue of coverage by the pool substantially equivalent coverage under health insurance or other health plan;

(2) Any person who is at the time of pool application eligible for health care benefits under the Medicaid provisions of title 71, chapter 5;

(3) Any person having terminated coverage in the pool, unless twelve (12) months have lapsed since such termination;

(4) Any person on whose behalf the pool has paid out one million dollars ($1,000,000) in benefits; or

(5) Inmates of public institutions and persons whose benefits are duplicated under public programs.

(b) Any uninsurable person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium, and who is not eligible for conversion, or who is not covered by substantially equivalent health plans, may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the involuntary termination, and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

(c) It is unlawful for any employer or insurer to entice or coerce any individual to participate in the pool who is otherwise eligible to participate in a group comprehensive health insurance plan for the purpose of reducing the group plan premiums or self-insurance costs. Any denial of coverage must be based upon preestablished policies and conditions that are mandated for the entire group and its participants. The board has the authority and responsibility to adopt policies and procedures that effectively implement this provision. Such policies and procedures shall be included in its plan of operation. The pool is authorized to enter into agreements with employer-sponsored health plans for employer-sponsored participation of its employees who are denied coverage based upon the preestablished policies and conditions required by this subsection.

SECTION 12.

(a) The board shall provide for administration of the pool by electing in its plan of operation to have the pool administered:

(1) By the commissioner through the state group insurance office;

(2) By selecting an administrator through a competitive proposal process; or

(3) Through a combination of both.

(b) If the board should elect to procure the services of an administrator, the board shall evaluate the proposals on criteria established by the board which shall include:

(1) The administrator's proven ability to handle accident and health insurance;

(2) The efficiency of the administrator's claim paying procedures;

(3) An estimate of total charges for administering the plan; and

(4) The administrator's ability to administer the pool in a cost-efficient manner.

(c)

(1) The administrator may provide for all eligibility and administrative claim payment functions relating to the pool.

(2) The administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing.

(3) The administrator shall provide for all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made; and

(B) Evaluating the eligibility of each claim for payment by the pool.

(4) The administrator shall submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(5) Following the close of each fiscal year, the administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year, and report this information to the board and the commissioner on a form as prescribed by the commissioner.

(6) All administrative costs of the pool shall be paid from the pool fund.

SECTION 13.

(a)

(1) The board shall be responsible for establishing all benefit levels associated with the operations of the pool.

(2) The health insurance policy issued by the pool shall pay only usual and customary charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury which exceeds the deductible and co-insurance amounts as established by the board and which are not otherwise limited or excluded.

(3) Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy.

(4) Once the board establishes the pool benefits and exclusions, it shall prepare a brochure outlining the benefits and exclusions of the pool benefit policy in an easy-to-read language and which shall be made reasonably available to participants or potential participants.

(b)

(1) The board has the authority to specify limitations and exclusions, specifically including exclusions for pre-existing conditions, in addition to the minimum benefits required under subsection (a).

(2) Such exclusions and benefits shall be generally reflective and commensurate with those contained in health plans provided through a representative number of large employers across the state.

(3) The board has the authority to establish deductibles, co-insurance and maximum out-of-pocket payments for eligible expenses.

(c) This act does not prohibit the pool from issuing additional types of health insurance policies with different types of benefits, which, in the opinion of the board of directors, may be of benefit to those individuals otherwise eligible for coverage.

(d) The board of directors may at its discretion design and employ cost containment measures and requirements such as, but not limited to, pre-admissions certification, concurrent inpatient review and preferred provider organizations which may make the pool more cost-effective.

SECTION 14.

(a) The board shall establish a qualified Medicare supplemental health coverage for eligible persons who are enrolled under title 1, part 1 of Public Law 89-97 and amendments thereto (Health Insurance for the Aged Act), known as Medicare. The plan of health care coverage must meet the minimum standard requirements for Medicare supplemental coverage as specified under chapter 7, part 14 of this title and Rule 0780-1-45 of the Rules and Regulations of the department of commerce and insurance. No benefits may be provided for expenses that are not Medicare-eligible expenses, except for prescription drugs. The board shall establish the scope of benefits for prescription drugs.

(b) The board shall establish rates for the Medicare supplemental plan that are reasonable in relation to:

(1) The benefits provided; and

(2) The risk associated with persons eligible for the plan.

SECTION 15.

(a) A pool policy offered under this act shall contain provisions under which the pool is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both spouses, the age of the younger spouse shall be used as the basis for meeting the durational requirement of this subsection.

(b) The pool may not change the rates for pool policies except on a class basis with a clear disclosure in the policy of the pool's right to do so.

(c) Pool coverage under this act shall provide that upon the death of an individual who is covered by the pool and who has dependents also covered by the pool as a result of the individual's coverage, the dependents may elect, within a period as established by the board, to continue coverage until such time as the deceased would have ceased to be entitled to coverage had the individual in whose name the coverage was issued lived.

SECTION 16. The commissioner shall adopt rules that:

(1) Provide for disclosure by a carrier of the availability of insurance coverage from the pool; and

(2) Implement this act.

SECTION 17. Neither the participation by insurers in the pool, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required under this act shall be the basis of any legal action, civil or criminal liability or penalty against the pool members, either jointly or separately.

SECTION 18.

(a) Premiums charged for coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses provided in the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

(b) The pool shall determine the standard risk rate by using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Except as provided in Section 14, maximum rates for pool coverage shall be one hundred fifty percent (150%) of the rates established as applicable for individual standard risks. In the event that the combined amounts of premium collections, the appropriation contained in the general appropriations act, and the assessment from the pool members do not result in an actuarial sound fund balance, the board will then have the authority to raise the premium to an amount in excess of the maximum, in order to place the pool in a fiscally sound condition. All rate schedules shall be submitted to the commissioner and the comptroller of the treasury for their approval.

SECTION 19. It is the express intent of this act that the pool be the last payor of benefits whenever any other benefit is available. Coverage under any pool policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(1) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or health benefit plans, including, but not limited to, self-insured plans and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The administrator of the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits

due from the pool may be reduced or refused as a setoff against any amount recoverable under this subdivision.

SECTION 20. The pool and the premium collected by the pool shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate and income, or any combination of them or similar taxes on revenues or income that may be imposed by Tennessee.

SECTION 21.

(a) The comprehensive health insurance pool fund shall be established as a separate account in the state treasury.

(b) Moneys in the comprehensive health insurance pool fund, including interest earned on such moneys, shall be invested by the state treasurer pursuant to §§ 9-4-602 and 9-4-603 for the sole benefit of that fund.

(c) Any moneys remaining in the comprehensive health insurance pool fund at the end of the fiscal year shall not revert to the general fund, but shall be brought forward to the next fiscal year for the exclusive benefit of the comprehensive health insurance pool fund.

SECTION 22. Whenever the board determines that the number of insured in the comprehensive health insurance pool has declined as a result of another state-sponsored health plan to a point that continuation of the comprehensive health insurance pool is no longer feasible, the commissioner of finance and administration and the board of directors shall develop and implement a plan for the orderly termination of the Tennessee comprehensive health insurance pool.

SECTION 23.

(a) All entities providing health care benefits, including, but not limited to, insurers, ERISA group health plans, health maintenance organizations and nonprofit hospital and medical service plans, are prohibited from considering the availability or

eligibility for medical assistance under 42 U.S.C. § 1396a, herein referred to as "Medicaid," when considering eligibility for coverage or calculating payments under their plans for eligible enrollees, subscribers, policyholders, or certificate holders.

(b) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for the health care items or services. Upon presentation of proof that the state Medicaid program or any provider who has contracted with the state to provide Medicaid services has paid for covered items or services, the insurer, ERISA group health plan, health maintenance organization, or nonprofit hospital and medical service plan shall make payment to the state Medicaid program, or contracted provider under the Medicaid program according to the coverage provided in the policy or contract on the same basis applicable to an agent or assignee of any other individual so covered.

PART 2 -- MANAGED CARE MEDICAL ASSISTANCE

SECTION 24. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following Sections 25 through 51 as new, appropriately designated sections:

SECTION 25. Sections 25 through 51 may be known and cited as the "Tennessee Managed Care Health Assistance Program."

SECTION 26. The purpose of this part is to make possible managed care medical assistance to those recipients determined to be eligible under this chapter to receive medical assistance that conforms to the requirements of title XIX of the Social Security Act and the regulations promulgated pursuant thereto including modifications made by the "Balanced Budget Act of 1997", Pub. Law No. 105-33. Medical assistance pursuant to this act may also be provided pursuant to any federal waiver received by the state that waives any or all of the provisions of title XIX or pursuant to any other applicable federal law to the extent adopted by means of an amendment to the required title XIX state plan. The commissioner shall be

authorized to promulgate necessary rules under Title 4, Chapter 5, including public necessity rules to meet the time-frame of this part.

SECTION 27.

(a) The commissioner of health, in conjunction with the commissioner of finance and administration is directed to develop and provide a Tennessee Medicaid program that consists of a mandatory managed care program for medically needy and categorically needy persons as defined by Title XIX of the Social Security Act, and children who are eligible for coverage under the State Children's Health Insurance Program pursuant to 42 U.S.C. § 1397aa et seq., consistent with the "Balanced Budget Act of 1997", Pub. Law 105-33 and in accordance with the provisions of this part. The commissioner shall develop an orderly transition plan for those enrollees in the TennCare program who qualify as Medicaid enrollees under this part. Transition plans shall also be developed for those persons who no longer qualify for Medicaid under this part but who qualify for the Comprehensive Health Pool Program under this act.

(b) Transition plans shall be developed in a manner to provide continuity of care for those persons who continue to qualify for any services under this act. Transition plans shall be implemented within ninety (90) days of the effective date of this act.

SECTION 28.

(a) Medicaid services under this part shall be provided through two (2) or more entities licensed as health maintenance organizations under title 56, chapter 32 and certified as risk-bearing entities, that meet the federal definition of managed care entities under 42 U.S.C. § 1396 u-2(a) and any regulations promulgated thereto. Such managed care entities shall contract with a reasonable and adequate network of health care providers to render health care services consistent with this part. The department shall contract with such managed care entities as appropriate to implement this part.

(b) The commissioner is authorized to establish by rule procedures for access to services to individuals exempt from mandatory enrollment in a managed care entity pursuant to 42 U.S.C. § 1396 u-2(a).

(c) The commissioner shall permit an individual to choose a managed care entity from not less than two (2) such entities that meet the applicable requirements of this part. An individual enrolled with a managed care entity shall be permitted to terminate or change such enrollment:

(1) for cause at any time, and

(2) without cause

(A) during the 90-day period beginning on the date the individual receives notice of enrollment, and

(B) at least every twelve (12) months thereafter.

Each enrollee shall be provided with notice of the right to change or terminate enrollment.

(d) The commissioner shall establish a default enrollment process consistent with 42 U.S.C. § 1396 u-2.

SECTION 29. The commissioner shall, by rule and through contract, require participating managed care entities to perform the following functions:

(1) Provide easily understandable enrollment notices, information and instructional materials;

(2) Make available to enrollees and potential enrollees in the entity's organizational area information regarding:

(A) the identity, locations, qualifications and availability of providers who participate with the entity;

(B) provide information about the rights and responsibilities of the enrollees under the Medicaid managed care plan;

(C) inform enrollees of the grievance and appeals procedures available to an enrollee and a health care provider to challenge or appeal the failure of the entity to cover a service;

(D) inform enrollees about all items and services that are available under the managed care Medicaid contract between the state and the entity that are covered either directly or indirectly through referral and prior authorization; and

(E) provide comparative information annually to enrollees relating to benefits and cost-sharing, service area and quality and performance.

SECTION 30. The commissioner shall require by rule and through contract that each entity, to the extent required by 42 U.S.C. § 1396 u-2(b):

(1) provide coverage for emergency services;

(2) protect enrollee provider communications;

(3) establish and comply with an internal grievance procedure;

(4) demonstrate adequacy of capacity and services;

(5) protect enrollees against liability for payment;

(6) not discriminate against providers as to participation, reimbursement or indemnification; and

(7) comply with requirements of federal law regarding maternity and mental health.

SECTION 31. The commissioner shall establish and maintain a quality assessment and improvement strategy consistent with 42 U.S.C § 1396 u-2(c). Each contract with a managed care entity shall provide for an annual external independent review as required by 42 U.S.C. § 1396 u-2(c).

SECTION 32.

(a) The commissioner shall establish and maintain the fraud and abuse, marketing, conflict of interest and physician identifier protections required by 42 U.S.C. § 1396 u-2(d).

(b) The commissioner shall establish a system of intermediate sanctions and temporary management, contract provision protections and prompt pay requirements, consistent with 42 U.S.C. § 1396 u-2(e) and (f), and require disclosures pursuant to 42 U.S.C. § 132 a-3.

SECTION 33. Tennessee Code Annotated, Section 71-5-103, is amended by adding the following as a new item:

( ) "Managed care entity" means an entity licensed as a health maintenance organization under title 56, chapter 32, and certified by the state as a risk-bearing entity, that meets the federal requirements of 42 U.S.C. § 1396 u-2(a) and regulations promulgated thereto.

SECTION 34. Tennessee Code Annotated, Section 71-5-101, is deleted.

SECTION 35. Tennessee Code Annotated, Section 71-5-102, is deleted.

SECTION 36. Tennessee Code Annotated, Section 71-5-103, is amended by deleting the last sentence of item (5) that begins with the words "To the extent".

SECTION 37. Tennessee Code Annotated, Section 71-5-106(k), is deleted, and by substituting instead the following language:

(k) Children eligible for coverage under the Children's Health Insurance Program, 42 U.S.C. §1397aa, shall be provided assistance pursuant to this act.

SECTION 38. Tennessee Code Annotated, Section 71-5-110, is amended by deleting the words "TennCare" wherever they may appear and by substituting instead the words "Medicaid Managed Care Services".

SECTION 39. Tennessee Code Annotated, Section 71-5-110, is further amended by deleting subsection (c) in its entirety.

SECTION 40. Tennessee Code Annotated, Section 71-5-117(f), is deleted and the following language is substituted instead:

The state's right to action shall include recovery for programs included in the "Comprehensive TennCare Reform and Health Insurance Program of 2001".

SECTION 41. Tennessee Code Annotated, Sections 71-5-118, 71-5-122 and 71-5-123, are amended by adding the words "or managed care entities" after the word "vendor" or "vendors" any time it may appear.

SECTION 42. Tennessee Code Annotated, Section 71-5-128, is deleted.

SECTION 43. Tennessee Code Annotated, Section 71-5-137, is amended by deleting the words "managed care organization" and by substituting the words "managed care entity" each place it may appear.

SECTION 44. Tennessee Code Annotated, Section 71-5-137, is further amended by deleting the word "TennCare" and substituting instead the words "Medicaid managed care Medicaid program" each place it may appear.

SECTION 45. Tennessee Code Annotated, Section 71-5-181, is amended by deleting subsection (b) and by appropriately renumbering remaining subsections.

SECTION 46. Tennessee Code Annotated, Section 71-5-188, is amended by deleting the word "TennCare" and by substituting instead the words "managed care Medicaid program."

SECTION 47. Tennessee Code Annotated, Section 71-5-189, is amended by deleting the words "of TennCare" and by adding the word "Medicaid" before the word "bureau."

SECTION 48. The Code Commission is directed to delete the word "TennCare" wherever it may appear in title 71, chapter 5, and substitute instead "Medicaid Managed Care Program."

SECTION 49. The commissioner of finance and administration is directed to take any action necessary to obtain the reinstitution of disproportionate share adjustments to the state

under the medical assistance program from the federal department of health and human services.

SECTION 50. Tennessee Code Annotated, Section 71-5-135, is deleted.

SECTION 51. The commissioner of finance and administration is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 52. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 53. This act shall take effect upon becoming law for the purposes of promulgating rules and regulations, and upon July 1, 2001 for all other purposes, the public welfare requiring it.